STATE OF CONNECTICUT
DEPARTMENT OF CHILDREN AND FAMILIES
PUBLIC HEARING TESTIMONY

HUMAN SERVICES COMMITTEE
MARCH 3, 2009

S.B. No. 843 AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS CONCERNING SOCIAL SERVICES

The Department of Children and Families **supports** S.B. No. 843 AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS CONCERNING SOCIAL SERVICES. This bill makes a number of changes to implement the Governor's budget, including a statutory change in section 3 of the bill to reflect the proposed closure of High Meadows, a DCF-operated residential facility in Hamden.

High Meadows currently serves 36 children and is the oldest and smallest of the four DCF facilities. Approximately 20 of the 36 are individuals with developmental disabilities and the staff at High Meadows do an outstanding job in meeting their needs. However, over the last several years, the Department has moved to serve children in their communities rather than in large congregate settings and we have been successful in greatly reducing the number of children who require residential treatment. We anticipate that the downward trend in residential census will continue and we believe that the reduction in utilization is appropriate and will result in better outcomes for the children we serve. The move to close High Meadows is consistent with this trend.

The closure of the facility will result in an annual operating savings of $6 million and a significant cost avoidance of $11.8 million in capital improvements.

H.B. No. 6523 (RAISED) AN ACT CONCERNING LICENSING OF ADOLESCENT SUBSTANCE ABUSE TREATMENT FACILITIES

The Department of Children and Families **offers the following comments regarding** H.B. No. 6523 AN ACT CONCERNING LICENSING OF ADOLESCENT SUBSTANCE ABUSE TREATMENT FACILITIES.

This bill would amend section 17a-145 of the general statutes to exempt those residential substance abuse treatment facilities that are licensed by the Department of Public Health (DPH) from also being licensed by DCF. Currently, four facilities: the Children's Center of Hamden; Midwestern CT Council on Alcoholism, Inc.; New Hope Manor, Inc.; and Rushford Center, Inc., are dually licensed.

We recognize that potential conflict issues regarding state agencies' licensure role and function have arisen in recent years, and that during these difficult economic times the Legislature is

naturally interested in evaluating any potential redundancies in state agency regulatory activities. We are happy to work with members of the committee and DPH on making the best choices regarding the licensing of these and other programs and services that serve children.

Please note that bill has an incorrect reference to the DPH licensure statute. The correct reference is section 19a-490, not section 19a-491.

H.B. No. 6525 (RAISED) AN ACT ESTABLISHING A TASK FORCE TO STUDY THE REORGANIZATION OF THE DEPARTMENT OF CHILDREN AND FAMILIES

The Department of Children and Families **offers the following comments** regarding H.B. No. 6525 AN ACT ESTABLISHING A TASK FORCE TO STUDY THE REORGANIZATION OF THE DEPARTMENT OF CHILDREN AND FAMILIES.

This bill would established a task force to study the Department of Children and Families, including: (1) an evaluation of the department's policies, practices and procedures, including, but not limited to, whether the Commissioner of Children and Families may suspend a child's visitation with his or her parent before an evidentiary hearing has occurred on the issue of visitation; and (2) consideration possible changes in the structure and organization of the department, including whether any functions of the department should be transferred to other departments or agencies.

We understand that this bill is likely intended to serve as a vehicle to address issues raised during the joint hearings of the Select Committee on Children and the Human Services Committee last fall. There are a number of similar bills before the Select Committee on Children, including: **S.B. No. 878** An Act Concerning the Prevention Role of the Department of Children and Families; **S.B. No. 879** An Act Concerning Oversight and Reorganization of the Department of Children and Families; **H.B. No. 6419** An Act Concerning Transparency and Accountability of the Department of Children and Families; **H.B. No. 6420** An Act Concerning a Leadership Audit of the Department of Children and Families. There is also **H.B. No. 6352** An Act Concerning Oversight of the Department of Children and Families, which was heard by the Human Services Committee on February 10th and remains before your committee.

The Department appreciates many of the concerns raised by Committee members and looks forward to working collaboratively to achieve consensus on a number of issues. We have already reached out to the leadership of both committees and welcome the continued dialogue.

We recognize that the task force membership in these bills may just serve as a "placeholder," but we believe that if you are to establish a task force or multiple task forces, that they should include individuals with expertise in the subject area and should include both executive and legislative branch appointments.

As you consider the establishment of a new task force, we would also point out that over the past three decades, there have been at least 11 studies conducted by either the Legislative Program Review and Investigations Committee or management consultants regarding the Department of

Children and Families. In fact, the Department's current organizational structure is, in part, based on prior recommendations from such studies. The following is a brief summary of these studies:

Year	Title/Author	Key Points
1977	*A Critical Review of Mandates and Resources in the Connecticut Department of Children and Youth Services by the Review Team of the DCYS Advisory Council*	Agency problems related to: • striking gap between department mandates and resources provided • transfer of authority incomplete; agency lacks full control over some key management functions; no mechanism for resolving interagency conflicts • lack of commitment on part of executive and legislature to improve agency performance Management issues: • crisis management operation; no evidence of commitment to long range planning or improved service delivery • functions not integrated; services remain three largely separate tracks • basic management documents nonexistent; management authority ambiguous and overlapping • staff turnover high, morale low; relationships with providers poor • information systems inadequate; lack information needed for informed decision making; cannot assess worker, contractor performance or client progress To address management issues recommend: • detailed management plan endorsed by governor, shared with legislature • clear table of organization, comprehensive budget with new categories related to policy, and automated information system capable of monitoring performance • advisory groups be given data to assess agency effectiveness, progress in implementing plan
1978	*Study of Juvenile Justice in Connecticut by the Program Review and Investigations Committee*	The committee found: • virtually no analysis is done by DCYS to indicate what treatment methods work with what kinds of delinquents • DCYS ability to oversee Youth Service Bureaus is questionable • A major problem of the Long Lane School is that of runaways and the Long Lane treatment manual contains no goal statement on the role or importance of maintaining a secure facility • Private agencies play a crucial role in addressing Connecticut's juvenile delinquency problem and are essential to the development of a continuum of needed services • DCYS reimbursement of private providers of juvenile delinquency services is inadequate and inefficient • Juvenile needs assessments are lacking • DCYS Office of Evaluation, Research, and Planning has not demonstrated its capacity to effectively evaluate programs • There are few additional standards, beyond licensing, for private providers To address these issues, the committee recommended: • More analysis of the effectiveness of various programs designed to treat juvenile offenders should be undertake by the department • The Law Enforcement Assistance Administration should provide technical assistance to DCYS to help the agency develop evaluation procedures that could be integrated into the department's system for managing funds • DCYS detention staff job classifications and salaries should be upgraded

		• Information about juveniles must be maintained and tracked in a more effective manner • DOC should be utilized by the department to provide technical assistance to Long Lane on security and custody matters • Long Lane's primary role should be limited to the treatment of a small population requiring secure custody • DCYS should articulate, as part of its master plan, clear policy on the use of private resources, including the development of programs equipped to handle difficult cases • DCYS should provide more reasonable cost related payments for private delinquency treatment services • DCYS should exercise aggressive leadership to stimulate the development of family-centered programs in the private sector • DCYS should require private programs to provide transitional aftercare services following release from residential treatment and reimbursement rates should be adjusted to reflect this additional requirement • A written plan should be developed by the DCYS Office of Evaluation, Research, and Planning which establishes priorities and specifically shows how and when major tasks will be accomplished • DCYS must update licensing standards, hire more qualified workers, and improve workers' training • DCYS must improve its communications with DSS, DMH, DMR, and the Juvenile Courts
1978	*DCYS: A Program Review by the Program Review and Investigations Committee*	The committee found: • DCYS managers are unable to effectively manage the operations of the department or to fully comply with statutory mandates • Management information systems are ineffective • Projections of caseloads and staffing requirements are insufficient • There are deficiencies in the child abuse and neglect reporting system • The timeliness of abuse and neglect investigations is not monitored • One in five cases has no written treatment plan and only 68% of those with treatment plans have had a current review • 50-70% of the children in DCYS care are not receiving routine medical examinations or other routine medical services • Many children are in foster care for more than two years without a permanent placement plan • The inadequacy of board and care funds for both foster and other private placements has been caused, in part, by the department's poor forecasting and budget preparation • DCYS has weak oversight, at best, of troubled youths between the ages of 16 and 18 who cannot be forced to stay in a foster home or a group home • DCYS has not fulfilled its prevention mandate To address these findings, the committee recommended: • DCYS draft a five-year rolling master plan together with a comprehensive budget • Fines be imposed for mandated reporters who intentionally fail to report suspected child abuse or neglect • DCYS implement a manual tracking system to provide more thorough information to supervisors • All DCYS foster care commitments must be limited to two years. 90 days before expiration of the commitment, DCYS should be required to file a petition with the Superior Court to either: (1) terminate parental rights, (2) revoke the

		commitment, or (3) extend the commitment for an additional two years based on a finding that continued commitment would be in the best interests of the child • DCYS must expedite the recruitment process for foster parents. The Department must recognize that foster parents make a vital contribution to the treatment of DCYS children • DCYS must not only improve its forecasting and budget preparation, but also place children in foster homes and other appropriate settings within the limits of physical, rather than fiscal resources, even if such a policy results in the need for a deficiency appropriation • DCYS must improve its supervision of difficult youth between the ages of 16 and 18
1987	*Study of Psychiatric Hospital Services for Children and Adolescents by the Program Review and Investigations Committee*	The committee found: • DCYS has not met its statutory mandate to complete a comprehensive child's mental health plan • DCYS has not assessed the demand for existing services to determine if supply of state beds was appropriately allocated among age groups, treatment needs, and regions • There is a high demand for hospital services but DCYS hospitals frequently operate under capacity • There is a lack of information on psychiatric hospital services available to children. No state or private agency maintains a centralized directory • Incomplete or sporadic compliance by hospitals with statutory client information reporting requirements is typical • The DCYS database does not provide accurate information on children treated for psychiatric problems in emergency rooms To address these issues, the committee recommended: • DCYS must meet its statutory mandate and complete a comprehensive child's mental health plan • DCYS must reassess the role of psychiatric hospitals in terms of bed space and regional services • DCYS should utilize psychiatric hospitals to their fullest if demand for psychiatric services is high • DCYS should develop and maintain a statewide telephone clearinghouse on public and private inpatient bed openings • DCYS should establish an emergency psychiatric services program to provide crisis intervention and triage in each region • DCYS should develop a plan to more thoroughly collect psychiatric emergency room information
1989	*Study of Juvenile Justice in Connecticut by the Program Review and Investigations Committee*	The committee found: • The contents of DCYS treatment plans for committed juveniles are lacking • There is an imbalance in the staff-to-client ratio between aftercare and Long Lane staff • There is an increase in the number of escapees from Long Lane and many escapees are serious juvenile offenders • Little new money, high utilization rates, rigid criteria, and lengthy acceptance processes all create a lack of private residential facilities for juvenile delinquents in the state To address these issues, the committee recommended: • DCYS include specific information in treatment plans and case files • Long Lane allocate a number of its correctional staff to aftercare services

		• DCYS either make Long Lane a secure facility with a fence or build a medium security unit attached to the existing structure • DCYS monitor treatment and care of committed children and should take care that the automatic review policy does not further constrict limited resources
1991	*Study of DCYS Child Protective Services by the Program Review and Investigations Committee*	The committee found: • The reorganization of DCYS has focused on protective services programs and case management • There is a need for an independent review of DCYS handling of cases to provide oversight. There are no random audits to ensure that practice follows policy • There are broad variations between regions in case management and an absence of uniform standards in the Department • DCYS does not follow up cases to ensure that treatment and service plans have been implemented. Reviews are only done every 6 months • Staff training is not a top priority and training is inadequate • There are a number of deficiencies in case management • DCYS is deficient in administering and funding community-based programs • DCYS social workers are an untapped resource in the evaluation of community-based programs To address these issues, the committee recommended: • The DCYS management team must evaluate measurements of program effectiveness • Program evaluations and monitoring of client outcomes should be placed in one division • DCYS create a comprehensive system for managing cases, evaluating client outcomes, and reducing administrative paperwork for social workers • DCYS should develop an independent case audit unit to monitor regional compliance with policy and procedure • DCYS should develop a Staff Development and Training Division • DCYS should reduce the caseloads of workers, particularly new workers • All protective service social workers should, within first 10 years of employment, obtain MSW • DCYS should install an on-line computer system with 24-hour access and develop outcome measures for evaluating the effectiveness of client interventions • DCYS should design a grant processing system that funds proportionate to success in treating clients and allows for the reduction of funds against ineffective programs. The success of programs should be measured against specific criteria. Data on program outcome measures should be collected and analyzed • As part of the program evaluation process, social workers and supervisors should be surveyed and asked to gauge program effectiveness • DCYS should develop and maintain a computerized database of all available community service programs
1995	*Study of DCF Foster Care by the Program Review and Investigations Committee staff*	The committee found: • DCF does not sufficiently focus on the placement of children which consumes over half of its resources and is the primary focus of its work • The DCF practice of matching and placing children does not conform to policy. The lack of information about children prohibits appropriate matching to foster homes and hinders foster parents' abilities to care for children • The certification of family relatives for foster care is a questionable practice

		with no centralized oversight • DCF practice is confusing for staff and providers. There is a repetitive effort to maintain two separate investigation units. Also, there is no scale of authority for DCF to enforce its investigation recommendations • DCF foster parents typically have a poor working relationship with the Department As a result of these findings, the committee recommended: • DCF should be reorganized to create divisions responsible for coordinating, licensing, managing, and quality assurance of all placement resources, including those specific to foster care • DCF implement a child-placing portfolio containing all relevant and necessary information and documents to adequately provide foster care to a child. A copy should be provided to foster parents • Division of Quality Assurance should have the same responsibilities for relative certification as it does for foster care licensing • There be investigations of abuse and neglect allegations against foster homes conducted by regional staff, and completed within 14 days of referral. There should also be an investigation resolution process.
1995	*Report on DCF Organization and Staffing by KPMG*	KPMG found: • There are numerous small divisions and units in DCF's organizational structure which hinder department integration and horizontal communication • The current organization structure ineffectively divides and groups some functions • Some functions currently performed in the central office can be performed more appropriately in the field or on a contracted-out basis • Central Office and staffing have grown substantially • There are a high number of managers/supervisors in central office relative to staff yet the span of control of these managers/supervisors is low • Additional layers of management exist in the functional layers than is necessary • The commissioner's span of control is too great, yet it excludes important areas of the agency such as health and mental health • Too much of the department's functional responsibility is concentrated under the deputy commissioner for programs (DCP). Combining programmatic and administration functions under the deputy commissioner for administration (DCA) may not be optimal • Planning and program development functions are lacking at a high level within DCF's organizational structure To address these issues, KPMG recommended: • DCF bring together all aspects of research, clinical planning, strategic business planning, program development, and policy development. Closely integrating these with DCF's implementation unit will strengthen DCF's implementation of the consent decree • The number of senior employees reporting directly to the commissioner should be reduced from 9 to 7 and the commissioner should hire an executive assistant. A chief of staff and a public information officer should report directly to the commissioner • DCF should eliminate both deputy commissioner positions and replace them with five equivalent-level senior managers overseeing: child welfare services; health; mental health and education services; administration and finance; program development and planning; and juvenile justice

		• The chief of staff, public information officer, and executive assistant positions should be created. The chief of staff should coordinate external relationships and interaction with the commissioner, as well as internal agency initiatives and responses to events. He/she would also supervise DCF's case investigation unit. The agency ombudsman and legislative liaison should report to the chief of staff rather directly to the commissioner as under the current structure. The public information officer should manage external communications. He/she should continue to report directly to the commissioner. The executive assistant to the commissioner should handle administrative tasks such as responding to correspondence and scheduling
1998	*Study of the DCF Bureau of Juvenile Justice by Loughran and Associates*	The consultants found: • Very little of the Juvenile Justice Reorganization Plan (mandated by PA 95-225) has been implemented, such as the reconfiguration of the Long Lane School and the development of a full continuum of community programs and parole services • Most of DCF's budget, administrative structure, and support systems are dedicated to its child welfare operations • Parole services, the community case management arm of the Juvenile Justice Bureau, suffers from its disconnection from the rest of DCF To address these issues, the consultants recommended: • The department must better integrate the Juvenile Justice Bureau • The Juvenile Justice Bureau's regional offices should be co-located with those of the Bureau of Child Welfare Services. They should be large enough and have enough computers, phones, and fax and copy machines to accommodate the number of parole officers and support staff assigned to a particular office • Administrative practices must be changed to allow for better integration of the juvenile justice function into the department • The Juvenile Justice Bureau's administration should be transferred to DCF's central office, and the bureau's director should report to the juvenile justice bureau chief rather than to the assistant superintendent of Long Lane
1999	*Study of the Department of Children and Families by the Program Review and Investigations Committee staff*	The committee found: • Goals of a consolidated children's agency -- leadership and advocacy for children's issues and integrated service delivery -- have not been fulfilled. • No overarching policy guides state government efforts to promote well-being of children and their families. • No formal structure exists to examine the "big picture" or coordinate services and resources of the many state agencies responsible for children. • Major barriers to integrated services are categorical funding, lack of a coordinating mechanism, and "turf wars" among programs and agencies; most effective incentive for interagency coordination is financial. • Noncategorical, flexible funding is more important to integration than organizational structure. • Children and families are best served by integrated, individualized care delivered through community-based systems. • Coordinating resources and services to achieve an integrated care system must be the priority of a single entity without responsibilities for providing direct services. • All three branches of government, not just DCF, have responsibility for prevention; coordinating prevention efforts needs to be one entity's focus. • Leadership and management for child protective services, children's behavioral health, and juvenile justice must be strengthened; each mandate must be an agency's priority to ensure it receives sufficient attention and resources.

		• Despite continuous efforts to "fix" DCF, it is plagued by systemic management deficiencies. • DCF's child protective services mandate dominates agency policy and resources; it must be a priority due to dramatic increases in the number and severity of child abuse and neglect cases as well as a federal court consent decree. • Children's behavioral health and juvenile justice mandates have been seriously neglected by DCF and the legislature and only receive attention in response to a crisis. • Separate state agencies can focus on each mandate to ensure leadership and parity; service delivery can be integrated through a statewide coordinating structure and "pooled" resources. As a result of these findings, the committee recommended: • the creation of a secretary for children responsible for coordinating state efforts to implement the state's policy on children and families. • realigning the responsibilities of DCF as follows: ·children's mental health and substance abuse shall be transferred to the Department of Mental Health and Addiction Services; juvenile justice shall be transferred to the Connecticut Juvenile Authority (CJA) -- a new statutorily created state agency; and protective services for abused, neglected, or abandoned children shall remain within DCF. • that DCF develop an assessment standard and tool to determine which calls require a full investigation response by its staff and which can be referred to a state-contracted community partnership for children for assessment and services. The differential response process shall be fully implemented by the fourth year of the phase-in of community partnerships.
2007	*Study of DCF Monitoring and Evaluation by the Program Review and Investigations Committee staff*	The committee found: • little attention has been given to examining DCF as a whole or assessing how well the agency is achieving its broad goals of safety, permanency, and well-being for all children and families. • while the department is responsible for carrying out four major mandates, monitoring and evaluation is focused primarily on the child protective services mandate, due largely to the ongoing impact of the federal *Juan F.* lawsuit consent decree and requirements of federal agencies. • there is greater emphasis on tracking how services for children and families are delivered rather than on assessing their end results. While high quality service delivery is important, the crucial indicator of effectiveness is whether programs are making a difference and achieving stated goals. In general, more attention to outcome information is needed throughout the DCF accountability system. • pockets of strength within the system, such as the *Juan F.* exit plan process and related DCF area office quality improvement processes, the department's licensing procedures, the agency's recently revised special review process, and the activities of on-site facility monitors. • Some major weaknesses were revealed as well. In particular, the agency's contracting process provides little accountability, consequences for poor performance are rare, and working relationships with private providers need improvement. The committee also found ineffective use of some important sources of feedback on services and programs, such as child fatality reviews, OCA investigations, and even the department's own program review reports and contracted evaluations. In part, these deficiencies are due to both fragmentation of quality improvement efforts within the agency and the fact that results data are not regularly integrated and analyzed. Both problems are related to the

		department's information systems, which are themselves fragmented and in some cases inadequate. Another challenge is a lack of department staff with the analytic skills and research experience needed to use results data and information. Further, there is no centralized place – like an agencywide strategic plan – where all DCF goals and information about service delivery and outcomes are brought together. • Duplication of external monitoring efforts also was revealed by the program review committee's examination of statutorily required DCF plans and reports. The committee determined several mandates could be eliminated without a loss of accountability, as certain documents have become obsolete or been replaced by newer sources of similar information. In addition, reducing the number and clarifying the purpose of reporting mandates could improve the quality of information on department results available to the legislature and the public. As a result of these findings, the committee recommended: • making agency goals explicit; • integrating quality improvement activities and incorporating best practices throughout the agency; • improving the quality and quantity of available data; and • promoting the use of results information to better meet the needs of children and families.